BIOMATRIX SpRx

ORAL ONCOLOGY REFERRAL FORM

TODAY'S DATE ________________

☐ CURRENT PATIENT ☐ NEW PATIENT

PLEASE FAX REFERRAL FORM TO:

☐ **BiologicTx - NJ** TEL: 877-567-8087 FAX: 877-567-8089
☐ **BiologicTx - CA** TEL: 800-404-1963 FAX: 800-404-4595
☐ **BiologicTx - IL** TEL: 888-892-7607 FAX: 877-567-8089
☐ **Decillion Healthcare** TEL: 800-622-9321 FAX: 866-548-8849
☐ **Elwyn Specialty Care** TEL: 855-359-9679 FAX: 610-545-6030
☐ **Factor Support Network** TEL: 877-376-4968 FAX: 805-482-6324
☐ **Matrix Health** TEL: 877-337-3002 FAX: 888-385-2805
☐ **Med Center Specialty Pharmacy** TEL: 855-633-5633 FAX: 304-344-0655
☐ **MedEx BioCare** TEL: 800-962-6339 FAX: 901-382-3091

Patient Name ________ SS# ________ DOB ________ ☐ Male ☐ Female
Street Address ________ Apt# ________ City ________ State ________ Zip ________
Daytime Tel ________ Cell ________ Email ________ Height ________ Weight ________ BSA ________
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physician Office Local Pharmacy Phone ________
Allergies ________ Comorbidities ________
Current Medications (if necessary, please fax a complete list) ________

PRACTICE NAME	ADDRESS	PHONE	PRIMARY CONTACT
________	________	________	________

PRESCRIBER INFORMATION (PLEASE INCLUDE PHYSICIAN NAME AND NPI#)

☐ ________ #________	☐ ________ #________	☐ ________ #________
☐ ________ #________	☐ ________ #________	☐ ________ #________
☐ ________ #________	☐ ________ #________	☐ ________ #________

Insured's Name ________ Relation to Patient ________
Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# ________ Prescription Card ☐ Yes ☐ No If Yes, Carrier ________
Tel ________ Fax ________ Policy/Group# ________
Bin# ________ Pcn# ________ RXID# ________ RX Group# ________

Diagnosis ICD-10:________ Cancer Stage: ☐ Stage 0 ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV ☐ Other ________
Has patient been treated previously for this condition? ☐ Yes ☐ No (If patient has been on Xeloda, please indicate dose and duration of therapy below)
Medications:________
Is patient currently on therapy? ☐ Yes ☐ No Medications: ________
Will patient stop taking the above medication(s) before starting the new medication?
☐ Yes ☐ No If yes, what is the washout period? ________

PRESCRIPTION — PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

SOLID TUMORS
☐ AFINITOR ☐ AFINITOR DISPERZ ☐ ALECENSA ☐ BRAFTOVI ☐ CABOMTYX ☐ ERIVEDGE ☐ FEMARA ☐ HYCAMTIN ☐ **INLYTA** ☐ IRESSA ☐ MEKINIST ☐ MEKTOVI ☐ NEXAVAR ☐ NOLVADEX ☐ ODOMZO ☐ RUBRACA ☐ STIVARGA ☐ **SUTENT** ☐ TAFINLAR ☐ TAGRISSO ☐ **TARCEVA** ☐ TEMODAR ☐ TYKERB ☐ VERZENIO ☐ VOTRIENT ☐ XALKORI ☐ XELODA ☐ **XTANDI** ☐ ZYKADIA ☐ ZOLINZA
Dosage: ________ Sig: ________ QTY: ______ Refills: ______

LIQUID TUMORS
☐ **BOSULIF** ☐ CALQUENCE ☐ EXJADE ☐ FARYDAK ☐ GLEEVEC ☐ JADENU ☐ JAKAFI ☐ RYDAPT ☐ SPRYCEL ☐ TASIGNA ☐ ZYDELIG
Dosage: ________ QTY: ______ Refills: ______
Sig: ________

SUPPORTIVE AGENTS
☐ ARANESP ☐ ARIXTRA ☐ EMEND ☐ EPOGEN ☐ GRANIX ☐ LOVENOX ☐ NEUPOGEN ☐ NEULASTA ☐ NPLATE ☐ PROCRIT ☐ XGEVA ☐ ZOFRAN
Dosage: ________ QTY: ______ Refills: ______
Sig: ________

☐ **KISQALI 200mg** *(must be administered in combination with other aromatase inhibitor)*
Sig: Take ☐ 600 mg ☐ 400 mg ☐ 200 mg by mouth daily for 21 days followed by a 7 day rest period
☐ Sig: with Letrozole 2.5 mg orally once daily throughout the 28-day cycle
QTY: ☐ 21 (200mg QD) ☐ 42 (400mg QD) ☐ 63 (600mg QD) Refills: ______

☐ **COTELLIC** Sig: Three tablets (60mg) for 21-days on and 7-days off, then repeat
☐ **ZELBORAF** Sig: Four tablets (960mg) every 12 hrs QTY: 240 tabs Refills: ______

☐ **ZYTIGA** Sig: 250 mg 4 QD QTY: ______ Refills: ______
Sig: ☐ w/ Prednisone: 5 mg BID w/ food QTY: ______ Refills: ______

☐ **ERLEADA** Sig: Take 4 tablets (240 mg) by mouth daily QTY: ______ Refills: ______
Give w/ a gonadotropin-releasing hormone (GnRH) analog if the patient has not had a bilateral orchiectomy

TEMOZOLOMIDE ☐ 5 mg ☐ 20 mg ☐ 100 mg ☐ 140 mg ☐ 180 mg ☐ 250 mg
Sig: ________ QTY: ______ Refills: ______

CAPECITABINE ☐ 150 mg ☐ 500 mg
Sig: ________ QTY: ______ Refills: ______

☐ **POMALYST** ☐ **THALOMID** ☐ **REVLIMID** ☐ **DEXAMETHASONE**
Adult Female of reproductive potential? ☐ Yes ☐ No
Female Child of reproductive potential? ☐ Yes ☐ No
☐ Male Child ☐ Adult Male
Dosage: ________ Sig: ________ QTY: ______ Refills: ______

☐ **NINLARO** Sig: ____ mg once weekly on days 1, 8, and 15 of a 28-day cycle, 1 hour before or 2 hours after a meal QTY: 3 Refills: ______
☐ **REVLIMID** Sig: ____mg for 21 days, then 7-days off, then repeat cycle QTY: 21 Refills: ______
☐ **DEXAMETHASONE** Sig: 40mg (10 tablets) once weekly on days 1,8,15, and 22 of a 28-day cycle QTY: 40 Refills: ______

☐ **IMBRUVICA** Sig: ________ QTY: ______ Refills: ______
WM 420mg, CLL 420mg, cGVHD 420mg, SLL 420mg; MCL 560mg, MZL 560mg all dosed once daily

☐ **IBRANCE** Sig: QD w/ food for 21 days, then 7 days off QTY: 21 Refills: ______
Sig: ☐ w/ Letrozole: 1 tablet (2.5 mg) QD QTY: 28 Refills: ______

VENCLEXTA ☐ Starter Pack: Week 1: 20mg po QD; Week 2: 50mg po QD; Week 3: 100mg po QD; Week 4: 200mg po QD
☐ Maintenance: 400mg po QD after completing starter pack dosing
☐ 10mg ☐ Wallet ☐ Unit dose
☐ 50mg ☐ Wallet ☐ Unit dose
☐ 100mg ☐ 120 Bottle ☐ Unit dose QTY: ______ Refills: ______

OTHER ________ Dosage: ________
Sig: ________ QTY: ______ Refills: ______

OTHER ________ Dosage: ________
Sig: ________ QTY: ______ Refills: ______

OTHER ________ Dosage: ________
Sig: ________ QTY: ______ Refills: ______

OTHER ________ Dosage: ________
Sig: ________ QTY: ______ Refills: ______

☐ **ALLOPURINOL** Dosage: ________
Sig: ________ QTY: ______ Refills: ______

LONSURF ☐ 15 mg/6.14 mg ☐ 20 mg/8.19 mg QTY: ______ Refills: ______
Sig: Take ____ mg (35mg/m² based on trifluridine component) 2x daily within 1 hr of completion of morning and evening meals on days 1 through 5 and days 8 through 12 of each 28-day cycle. (round dose to nearest 5mg, max of 80mg/dose)

▬ = Restricted access medication as of June 2017

By signing this form and utilizing our services, you are authorizing BioMatrix Specialty Pharmacy, its subsidiaries and their employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies where allowed by law or contract.

Prescriber's Signature *Dispense as written (signature required. NO STAMPS)* **OR** *Product Substition Permitted (signature required. NO STAMPS)* **Date** ________

Prescriber's Email ________

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